

An evaluation of referrer factors for 98,671 referrals made to the West Yorkshire oral surgery managed clinical network over a three-year period

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Key points

Describes referrals for a tri-speciality MCN over 36 months with insight into the service demand for oral surgery, oral medicine and maxillofacial surgery in West Yorkshire and highlights referral behaviours showing that 60% of all referrals are accounted for by 10% of referrers.

Oral surgery referrals accounted for over 75% of all referrals of which the majority were exodontia. Almost 20% of all referrals were in the 'other' category.

Highlights the need for further studies both of a quantitative and qualitative nature to better understand referrer behaviours and how these impact on future service design and workforce training.

Abstract

Introduction Patients referred from primary dental care to hospital-based specialists in high volumes can contribute to significant NHS service pressures. Surprisingly, little is understood about what contributes to referral factors.

Aims To gain new insight into the referral factors from primary dental care by interrogating the tri-speciality West Yorkshire managed clinical network (MCN) referral pathway data for a 36-month period (2016–2019).

Methods Anonymised referrals from the electronic referral management system were collated for analyses.

Results There were 98,671 referrals within the 36-month period, 12.3% of which were rejected. Of those accepted for triage, 76% were directed at oral surgery, with >60% accounted for by exodontia. In total, 10% of referrers accounted for 60% of all referrals. Peak referral occurred five years after General Dental Council registration.

Discussion This is the first report of referral data from a tri-speciality MCN with exodontia referrals predominating. The data set demonstrates variation in referrer behaviours despite referral guidance. Referrals should be based upon patient need but patterns observed in this study suggested possible associations with high and low referral patterns which warrant further research.

Conclusions Interrogation of the referral database suggests that there are interesting patterns of referral which may be associated with characteristics of the referrer as well as their patients' needs. Further investigation could inform improved processes and service design, as well as education delivery and workforce development.

Introduction

The referral of patients from primary dental care to hospital-based specialists is a long-established model in the UK. Over time, referral numbers grew, exposing the limitations of a demand-driven approach within increasing pressure on NHS resources. To help meet this challenge, the NHS England 'Five year forward view'¹ set the policy for introduction of managed clinical networks (MCNs). MCNs are an established

healthcare model that aim to provide care in a timely fashion at an appropriate location that is delivered by the most suitable professional in the networked area.² In brief, there is greater flexibility in how care is provided compared to the established model of primary care dental team referral directly to hospital specialists, with attendant advantages for patients and NHS services.

NHS England went on to publish the 2015 'Guide for commissioning oral surgery (OS) and oral medicine (OM)³ to support NHS commissioners to offer a 'consistent and coherent approach' to commissioning services, for example in OS, across three levels of care within an MCN approach. Levels 1 and 3 reflect care delivered by general practitioners and specialist/consultant led services (3a and 3b), respectively. Level 2 care is delivered by dentists with skills over and above those

expected of a general dental practitioner who are working within a networked approach that includes patient pathways. The levels of care are not tied to the setting of the provider and may include primary care or hospital settings.

In 2004, the introduction of the NHS Choose and Book System⁴ in England, an electronic referral management system (eRMS) for general medical practitioners (GMPs) to refer to specialist medical services, ended the traditional paper letter referral in that area of healthcare. It empowered patient choice over service location and gave the referrer more autonomy.⁵ The eRMS has been associated with a reduction in inappropriate referrals, waiting times and duplicate referrals.⁵ In addition, patient satisfaction increased. This represented a step change with subsequent eRMS referral development, in part informed by the data that digitalisation generated.

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By contrast, dentistry largely continued with a paper-based referral process. However, there has been an increasing switch to eRMS in dentistry over recent years, but the pace, prioritisation and system choice has been in response to local or regional drivers that contrasts with the NHS e-Referral system used universally across England by GMPs. This difference is due to the central funding of general practitioner IT systems, whereas other primary care providers, including dentists, were not included in this NHS funding.

Provision of care that falls within the scope of OS, oral and maxillofacial surgery (OMFS) or OM varies across the UK, reflecting how local services have developed over time. These areas of clinical practice collectively account for the majority of all referrals made by the dental team, yet surprisingly, little is understood about referrer factors. New insight has the potential to inform improved processes and service design, as well as education delivery and workforce development.

The West Yorkshire Oral Surgery MCN (WYOS MCN), established in October 2016

has a geographical footprint that is home to 1.3 million people. Given the overlap in clinical practice between OS, OMFS and OM, the WYOS MCN established a referral form for each one, but manages these through a single eRMS. The aim of this study is to gain insight into the referral factors which are contributory to the pathway, by interrogation of the WYOS MCN referral pathway data for a 36-month period (2016–2019).

Materials and methods

Referral system

All referrals for the WYOS pathway since its inception on 1 October 2016 have been made through a single eRMS, which is summarised in Figure 1 and additionally by Montgomery-Cranny *et al.* 2017.⁶

Potential referrers are required to make decisions that are informed by referral guides and related documentation to promote best use of the processes. Clear direction is given that suspected cancer referrals should be referred via the two week wait pathway and not via this eRMS. Within the WYOS

pathway, referrers are required to choose one of three referral forms; OS, OMFS or OM (Appendices 1, 2 and 3). Each referral form includes a structured approach for the clinical focus of the referral and is designed to acquire a minimum data set through the use of mandatory questions. Each referral form includes an ‘other’ category for conditions that do not fit one of the named categories. As part of the referral process, the referrer in liaison with the patient is asked to select a preferred provider with choice informed by ‘nearest’ or ‘soonest’ options.

After receipt, each referral is checked for completeness of essential administrative details with referrals returned to the referrer if these are incomplete. Referrals that meet the required administrative standards are triaged either centrally (OS) or by the referrer-selected local provider (OMFS and OM). Triage takes account of the sufficiency of clinical information to make an informed decision and appropriateness for the service in question. After central triage, allocation of accepted OS referrals to providers is determined by referrer/patient choice and capacity within the overall MCN. It is important to note that the choice of referral form does not determine the provider. For example, care that follows a referral made on an OS form is often provided by OMFS.

Referral data

Referral data for the three specialties OM, OMFS and OS were acquired from the eRMS provider for the dates October 2016 to September 2019 inclusive. Agreement was sought from the commissioners and WYOS MCN. Ethical approval was not required as this is a service evaluation with secondary use of data, as stated by the Information Commissioner’s Office. There

Fig. 1 Overview of the WYOS pathway

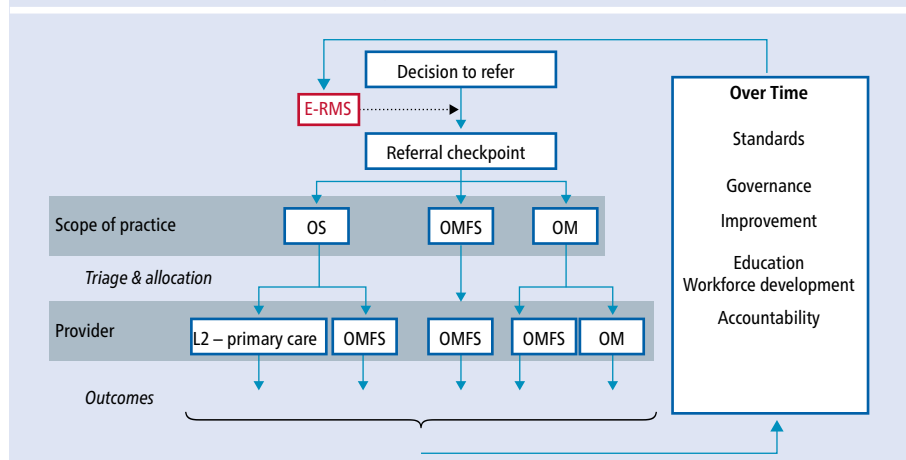


Table 1 Summary of referrals received for clinical triage over the 36-month period summarised by 12 month periods and the three referral forms used

Time period*	Oral surgery		Oral medicine		Oral and maxillofacial		All referrals	
	Total received	Total (%) rejected**	Total received	Total (%) rejected**	Total received	Total (%) rejected**	Total received	Total (%) rejected**
2016–2017	21,550	3,171 (14.7)	3,872	336 (8.6)	3,936	589 (14.9)	26,358	4,096 (15.5)
2017–2018	23,383	3,351 (14.3)	4,564	290 (6.3)	3,509	261 (7.4)	31,456	3,902 (12.4)
2018–2019	29,918	3,807 (12.7)	4,668	207 (4.4)	3,271	186 (5.6)	37,857	4,200 (11.0)
Totals	74,851	10,329 (13.7)	13,104	833 (6.7)	10,716	1,036 (9.6)	98,671	12,198 (12.3)

Key:
 * = October to September inclusive
 ** = Reflects the referrals rejected at clinical triage expressed as a number and (percentage)

were no patient-identifiable data within the spreadsheet. These data were exported from the eRMS into a Microsoft Excel (Microsoft Corporation, 2018) spreadsheet and cleansed into the speciality-specific categories as detailed in the results section.

In addition to this, the numbers of new registrants each year were acquired from the General Dental Council (GDC) and plotted against the years since first registration of the local referrers; referral numbers for each referrer were formatted into deciles.

Results

Total number of referrals received for clinical triage over 36 consecutive months

A total of 98,671 referrals were made through the eRMS over the 36-month study period starting 1 October 2016 (Table 1).

Of these, 12.3% ($n = 12,198$) were rejected at clinical triage due to reasons such as no radiographs, inappropriateness of referral and insufficient clinical details. Fluctuations in the number of referrals received per month across the 36-month study period were evident, as shown in Figure 2, that started in October 2016 (month 1) with the introduction of the WYOS MCN. Transient reductions are evident in August (months 11, 23 and 35) and December (months 3, 15 and 27).

Each referral form requires information about the reason for referral within several broad categories. There was a wide distribution in the numbers of referrals made within each referral category (Table 2).

Distribution of referrers by year since GDC registration and primary registrable qualification

A total of 1,800 individual referrers made a referral that was accepted for clinical triage. Of these, 3.5% ($n = 63$) had an invalid GDC number and accounted for 64 referrals. Consideration of the number of referrals made by years since GDC registration identified that the peak for referrals was five years after GDC registration and thereafter fell (Fig. 3). UK graduates made 75% of all referrals with the remainder by overseas graduates.

A regression analysis was carried out on the distribution of referrers, years since first registration and referral numbers which showed no significant F-test and no significant coefficients; therefore, the numbers of years since graduation is not significant in the referral

Fig. 2 Referrals received for clinical triage by month over the 36-month period

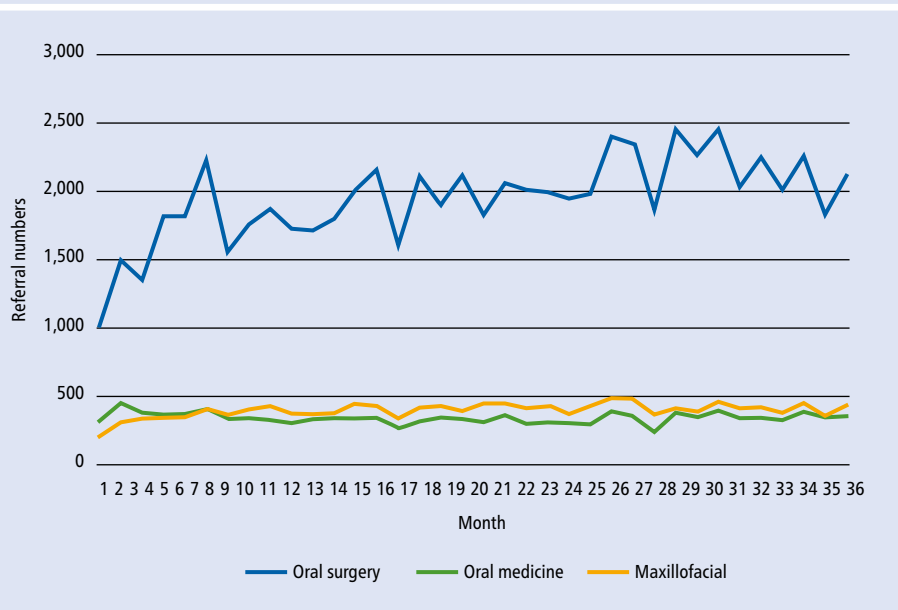


Table 2 Cause for referral, as selected by the referrer, by 12-month period. For each form, the referral categories are presented in order of descending selection apart from the 'other' choice, which is presented last

Form	Referral category	2016–2017	2017–2018	2018–2019	Totals (%)
OS	Difficult extraction	6,252	6,001	4,490	16,743 (16.9)
	Third molars	4,101	4,929	3,573	12,603 (12.7)
	Removal of roots	3,850	4,923	7,649	16,422 (16.6)
	Routine extraction	3,516	3,518	2,689	9,723 (9.8)
	Impacted teeth	1,962	2,029	1,395	5,386 (5.4)
	Surgical exposure	309	447	277	1,033 (1.0)
	Surgical endodontics	243	165	71	479 (0.4)
	Other (OS)	1,317	1,371	9,774	12,462 (12.6)
OM	Soft tissue (OM)	2,829	3,506	2,271	8,606 (8.7)
	Orofacial pain	316	382	293	991 (1.0)
	Salivary gland (OM)	126	134	99	359 (0.3)
	Oral presentation of wider problem	56	72	51	179 (0.1)
	Other (OM)	545	470	1,954	2,969 (3.0)
OMFS	Soft tissue (OMFS)	829	890	578	2,297 (2.3)
	Temporomandibular joint	738	870	16	1,624 (1.6)
	Hard tissue	545	487	399	1,431 (1.4)
	Trauma	78	76	55	209 (0.2)
	Salivary gland (OMFS)	78	66	51	195 (0.1)
	Facial deformity	32	22	19	73 (0.07)
	Severe swelling	9	51	10	70 (0.07)
	Other (OMFS)	1,614	1,035	2,142	4,791 (4.8)
Total		27,558	31,480	34,047	98,671 (100.0)

numbers. Figure 3 shows that the number of WYOS MCN referrers mirrors that of the UK picture of the numbers of new dentists registered (data acquired from the GDC).

Numbers of referrals made by individual GDC registrants

There was wide variation in the number of referrals made by each GDC registrant, with 10% of all referrers referring 60% of the total number of referrals in the three-year period (Fig. 4). The most frequent referrers (top 10% of referrers [n = 180]) followed a similar distribution to the overall cohort, with UK graduate registrants accounting for 77%.

Discussion

Better patient access and better resource use are at the heart of the NHS England ‘Five year forward view’¹ and the COVID-19 pandemic from 2020 is sharpening the focus. There are challenges associated with how routine NHS care is most effectively recovered. This aligns with the need to reduce patients visiting hospitals for care which could be delivered in other settings, closer to patients’ homes. The pandemic has also highlighted the importance of preparing the workforce to meet the changing oral health needs of patients and services.⁷

This is the first report of an MCN with an eRMS that collectively includes referrals made to OS, OMFS and OM specialties by the dental team. The establishment of this MCN coincided with the introduction of the first eRMS in the region and provides powerful opportunities to inform planned changes to service design and educational development of the workforce with the goal of improving patient care. The eRMS is used by primary care dental referrers and referrals from others, such as general medical practice teams and hospital-based specialists, come via other routes. Accordingly, the data presented are representative of the vast majority of all referrals received, but not all.

Referral categories in the three referral forms used brings insight into service demand. This is of benefit for referral categories with high and low referral numbers. Numbers are small for some categories such as facial deformity and facial pain; the care pathways are multi-disciplinary. Duplication of complex services needs to be avoided and it is important that patients are able to access these services in a timely manner. By contrast, care for referral categories with high numbers is delivered by

Fig. 3 The distribution of referrers by year since GDC registration

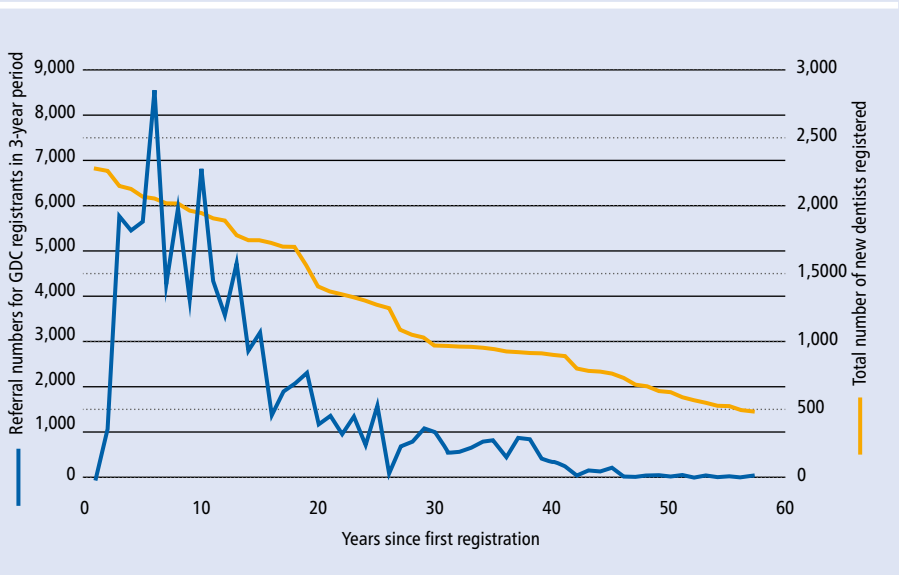
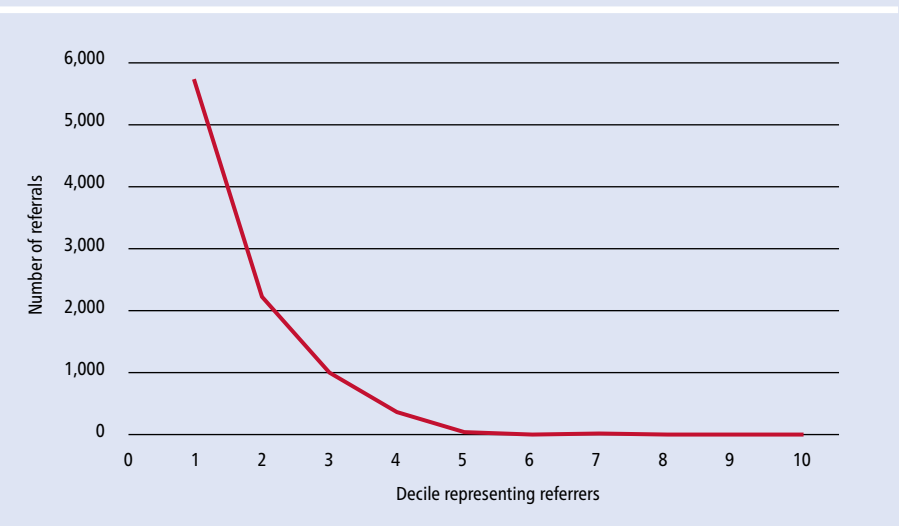


Fig. 4 Numbers of referrals made by individual GDC registrants in deciles



multiple providers who should be delivering care to agreed, minimum standards and shared quality assurance processes. Exodontia in one form or another accounted for over 60% of all referrals and is likely to be an underestimation given the greater than expected use of the ‘other’ category. This is consistent with past reports that have highlighted the high referral numbers for Level 2 or 3 OS, including the Getting It Right First Time report for OMFS.⁸

The findings of this study indicate a need to review the referral guidelines and referral categories, as well as how these are used by referrers to ensure there is clarity over which referral form and referral category should be selected. The number of referrals rejected at clinical triage was high at 12.3% and creates additional work and patient care delays. A further driver for change is evident from the

choice of ‘other’ for all specialties and the rise in its use over the three-year period. Without further qualitative analyses, the appropriateness of such referrals cannot be assessed. It would suggest that either referrals do not fulfil the criteria for the specified categories, or there is scope for more proactive feedback to referrers to limit the use of ‘other’. The ‘other’ category referrals dilute the value of a referral category approach and are a regression to the past paper letter referral approach. The use of ‘open text’ boxes on referrals provides an opportunity for additional information but only once a specific referral criterion has been chosen.

The variation in referral numbers by year since GDC registration is striking and 60% of all referrals are accounted for by 10% of referrers. Within the top 10%, there appears to be no immediate correlation in the years since GDC

registration and number of referrals, with 77% (n = 138) of the top 10% of referrers (n = 180) being UK graduates. Overall, the percentage of referrers with a UK primary dental qualification was similar (75%) to the 2019 GDC data for all registered dentists (72%).⁹ A small number of referrals could not be linked to a GDC number but were otherwise valid. These did not have a meaningful impact on data interpretation. Therefore, in this study, referral numbers do not correlate with an 'early years' referrer or overseas graduates. It is important to note that it is not years since graduation and the data must be interpreted accordingly, particularly for overseas registrants who may have worked for many years before registering to work in the UK.

This study includes the largest number of referrals reported for dentistry with recognition that not all referrers would have been working for the whole three-year period and some findings may represent chance. The medical literature reveals a mathematical model which calculates the amount of variation in the rates of referral is likely to be caused by chance alone.¹⁰ Although this model is applicable to GMPs, the larger size of their referral base compared to that investigated here limits its utility. The heterogeneity of the data presented contrasts with that of Coulthard¹¹ who reported that 96% of a sample of 400 GMPs in one city referred up to ten patients per month for OS care. In this study there is a subgroup of referrers who make high numbers of referrals. This group is of particular interest for further investigation to understand the reasons why. The reasons for this diversity of referral behaviour are likely to be multifactorial, reflecting factors linked to the individual registrant, the running of the practice, location of practice and patient-related factors. However, it is important not to draw unfounded conclusions that their referral patterns are inappropriate. By contrast, some GDC registrants make very few referrals and it is reasonable to question the reasons for this also.

The reasons for the high service demand for exodontia in this referral series need to be

better understood. There is a body of published work that explores the self-reported confidence of registrants and included reports that new foundation trainees have low confidence levels with regards to OS.^{12,13} There has been a related focus on the undergraduate and dental foundation training in OS and whether this is sufficient. It might be expected that referral numbers would peak in the years immediately following completion of foundation training, one year after first GDC registration for UK graduates. This is not the case in this large series and the peak at five-years post GDC registration and the subsequent gradual reduction cannot be currently clearly explained. It is probable that the underlying reasons are multifactorial and care has to be taken to not assume that this can be attributed to variations in undergraduate and early career experiences over time. It has been reported that postgraduate training in OS, either as a short course or recognised post-graduate training programme, is a factor contributing to referral behaviours in OS.¹¹

The data presented illustrate the value of collectively managing referrals made on OS, OMFS and OM electronic referral forms and how these link to the care provider. Furthermore, it highlights the potential for this to be strengthened by further developing resources and processes to support choice about selection of referral categories, alongside additional patient pathway development.

Conclusions

In conclusion, this study highlights the potential for three-speciality eRMS data to inform future provision of patient care through improved processes, service design and workforce development. However, further qualitative and quantitative investigation of this data is required. In particular, there is a need to better understand the referral factors which contribute to such high OS referrals of which the majority are exodontia.

Ethics declaration

The authors declare no conflicts of interest.

Author contributions

The main author is Richard Moore, with equal contributions from Gail Douglas and Iain Pretty. Alan Mighell is the supervising and advisory author for the group.

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YORKSHIRE & HUMBER REFERRAL FORM Please consult the website for copies of the referral guidance document, directory of services for provider information and for details on the referral system. www.dental-referrals.org

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Please describe why specialist care is required? Please describe any previous treatment for the condition referred. For third molars please explain how NICE guidelines are met? NICE criteria must be completed or the referral form will be returned to you. Please justify any routine extractions. <small>Click here to enter text.</small>																																																																												
If your referral is triaged to secondary care – please provide an indication of your patient's hospital of choice (see website for options): <small>Click here to enter text.</small>		If your referral is triaged to primary care – please provide an indication of your patient's provider of choice: (see website for options) <small>Click here to enter text.</small>																																																																										
I have read and understood the guidance notes for referrals of this type (see details on dental-referrals.org)																																																																												
SIGNED: _____																																																																												
PLEASE COMPLETE A MEDICAL HISTORY FORM – COPY URN TO THIS FORM – ENSURE ALL BOXES ABOVE ARE COMPLETED ADDITIONAL INFORMATION / LETTERS ETC MAY ACCOMPANY THE REFERRAL BUT MUST REFERENCE THE URN																																																																												
<small>Your referral should be posted to: Dental Referral Management Centre, Stannian Fold, Lymn, Warrington, WA13 9AB with all attachments.</small>																																																																												

Appendix 1 Oral surgery referral form

YORKSHIRE & HUMBER REFERRAL FORM Please see reverse of form for guidance notes and where to send your referral. Please note that the latest information, guidance and electronic forms are always available at www.dental-referrals.org

ORAL AND MAXILLOFACIAL SURGERY				
Age of Patient in years: <small>Click here to enter text.</small>	Patient's Title & Name: <small>Click here to enter text.</small>	Sex F	Date of Birth (DD/MM/YY) <small>Click here to enter text.</small>	
Patient's Address: <small>Click here to enter text.</small>				
Patient's Town or City: <small>Click here to enter text.</small>		Preferred Contact No: <small>Click here to enter text.</small>	Patient's Postcode <small>Click here to enter text.</small>	
Referrer's Name: <small>Click here to enter text.</small>	Practice Postcode: <small>Click here to enter text.</small>	Date of Decision to refer <small>Click here to enter text.</small>	Interpreter required? <input type="checkbox"/> YES / <input type="checkbox"/> NO	Language? <input type="checkbox"/> YES / <input type="checkbox"/> NO
Practice Name and Address: <small>Click here to enter text.</small>		Practice Phone Number: <small>Click here to enter text.</small>		
GDC Number: <small>Click here to enter text.</small>	Care Type (Routine or Urgent) <small>Click here to enter text.</small>	URN: <small>Click here to enter text.</small>		
If Urgent Care please state why: <small>Click here to enter text.</small>				
Patient's GP Name and Address including Postcode: <small>Click here to enter text.</small>				
Main Reason for referral: <input type="checkbox"/> TRAUMA <input type="checkbox"/> ORAL SOFT TISSUE (EG POLYP) <input type="checkbox"/> ORAL HARD TISSUE (EG JAW CYST) <input type="checkbox"/> FACIAL DEFORMITY <input type="checkbox"/> OTHER** / *** / **** <input type="checkbox"/> SALIVARY GLAND DISEASE <input type="checkbox"/> TMJ <input type="checkbox"/> SEVERE SWELLING (NOT EMERGENCY)				
**If other, describe here or use to provide more information. Please add additional sheets as necessary (quoting URN) <small>Click here to enter text.</small>				
PLEASE NOTE THAT THIS FORM SHOULD NOT BE USED FOR SUSPECTED CANCER REFERRALS. * FOR ORAL MEDICINE PROBLEMS PLEASE USE THE ORAL MEDICINE REFERRAL FORM Please attach radiographs if relevant				
Patient's principle complaint. Please describe any previous treatment or hospital visits for the condition. <small>Click here to enter text.</small>				
PATIENT'S MEDICAL HISTORY AND CURRENT PRESCRIPTION DRUGS <small>Click here to enter text.</small>				
Please provide an indication of your patient's hospital of choice: <small>Click here to enter text.</small>				
I have read and understood the guidance notes for referrals of this type (see details on reverse or at dental-referrals.org)				
SIGNED: _____				
ADDITIONAL INFORMATION / LETTERS ETC MAY ACCOMPANY THE REFERRAL BUT MUST REFERENCE THE URN				
<small>Your referral should be posted to: Dental Referral Management Centre, Stannian Fold, Lymn, Warrington, WA13 9AB with all attachments</small>				

Appendix 2 Oral and maxillofacial surgery referral form

Save Print Reset Please see reverse of form for guidance notes and where to send your referral. Please note that the latest information, guidance and electronic forms are always available at www.dental-referrals.org

YORKSHIRE & HUMBER REFERRAL FORM ORAL MEDICINE				
Age of Patient in years:	Patient's Title & Name:	Sex	Date of Birth (DD/MM/YY)	
Patient's Address:				
Patient's Town or City:		Preferred Contact No:	Patient's Postcode	
Referrer's Name:	Practice Postcode:	Date of Decision to refer	Interpreter required? <input type="checkbox"/> YES / <input type="checkbox"/> NO	Language? <input type="checkbox"/> YES / <input type="checkbox"/> NO
Practice Name and Address:		Practice Phone Number:		
GDC Number:	Care Type (Routine or Urgent)	URN:		
If Urgent Care please state why:				
Patient's GP Name and Address including Postcode:				
Main Reason for referral: (Please attach radiographs if relevant) <input type="checkbox"/> ORAL SOFT TISSUE <input type="checkbox"/> SALIVARY GLAND DISEASE <input type="checkbox"/> ORAL PRESENTATION OF WIDER PROBLEM <input type="checkbox"/> OTHER** / *** / **** <input type="checkbox"/> OROFACIAL PAIN				
**If other, describe here or use to provide more information. Please add additional sheets as necessary (quoting URN)				
Please provide details of patient's smoking status including daily tobacco consumption (e.g. cigarettes/day) and units of alcohol consumed per week				
**PLEASE NOTE THAT THIS FORM SHOULD NOT BE USED FOR SUSPECTED CANCER REFERRALS Please do not use this form for dento-alveolar referrals – please use oral surgery form				
Patient's principle complaint. Please describe any previous treatment or hospital visits for the condition.				
PATIENT'S MEDICAL HISTORY AND CURRENT PRESCRIPTION DRUGS				
Please provide an indication of your patient's hospital of choice: <input type="checkbox"/> ORAL MEDICINE – LEEDS <input type="checkbox"/> ORAL MEDICINE – SHEFFIELD <input type="checkbox"/> LOCAL MAXILLOFACIAL UNIT (please state)				
I have read and understood the guidance notes for referrals of this type (see details on reverse or at dental-referrals.org)				
SIGNED: _____				
ADDITIONAL INFORMATION / LETTERS ETC MAY ACCOMPANY THE REFERRAL BUT MUST REFERENCE THE URN				
<small>Your referral should be posted to: Dental Referral Management Centre, 6 The Offices, Pool Lane, Stannian Fold, Lymn, Warrington, WA13 9AB with all attachments</small>				

Appendix 3 Oral medicine referral form